Palliative Care Committee Minutes

Friday, January 6th, 2:00 – 3:30pm
1650 Mission Street, 5th floor, Golden Gate room

Present: Shireen McSpadden (co-chair), Christine Ritchie (co-chair), Terry Hill, Redwing Keyssar, Dawn Gross, Anne Hughs, Eric Weiss, Ramona Davies, Megory Anderson, Jeff Newman, Bill Verducci, Loren Porgir, George Kellar, Joan Teno, David Zwicky, Rachel Main, Glen Galanich, Parag Gupta, Bahar Monem, Meredith Heller

DAAS Staff: Valerie Coleman

Overview of the Workgroup's Potential Partnership with Stupski

Introduction to Stupski Foundation
Loren, Glen, and Parag gave an overview of the Stupski Foundation, their priorities, and how they got connected to the Palliative Care workgroup, as well as discussed the possibility of partnering.

Purpose of Needs Assessment
Joan Teno gave a presentation on her work in Rhode Island as an example of how SF can move forward. She discussed how a needs assessment can lead to change in behavior by highlighting existing conditions.

- Suggested key components of a needs assessment including death data, Medicare fee for service billing data, examination of mandatory assessment for skilled nursing facilities and nursing homes, bereaved family or next of kin survey, and narrative interviews.
- Discussed specific examples that her team utilized in this process, such as the power of a narrative story, highlighting the gaps simply across a 10yr span, lessons learned from Oregon, etc.
- **In sum:** the POLST is a tool, not an end of itself; the Oregon effort was multifaceted; recognition that this is a process, not a static event' people die of catastrophic, unpredictable event; and we need a variety of tools that can be tailored to meet their needs.

Breakout sessions
Workgroup broke out in three groups to discuss the following two questions.
> **1. What would success look like if we met our vision to improve palliative care services and access in the SF Bay Area?**
> **2. What data do you need to achieve the success you described in answering question 1?**

(**NOTE:** transcribed from white board notes, when words were not legible, I marked it with a "-----" to signify that)

Breakout Group Responses

<u>**WHAT WOULD SUCCESS LOOK LIKE:**</u>
Group A:
- Earlier referral & intervention;
- ---- access systems/patient's wishes heard;
- Increase education and awareness;
- Patient die in the setting of their wishes;
- Care accessible in any setting;
- Reimbursement aligned with patient wishes/ setting -----
- Reduction in ----- suffering
- Integration of entire social, faith, community and non-traditional partners;
- Anticipate who needs services earlier;
- A competency of providers in palliative care;
- Vulnerable population access is assured!
- Data exchange/access systems

Group B:
Big picture:
- Access
- Quality
- Culturally sensitive and appropriate care to San Franciscans

Specifics:
- Hospice and PC workers who speak every language represented in SF, conversant in cultural norms;
- A lot of people able to conduct conversations;
- Everyone has a surrogate decision maker;
- Everyone understands what to ask for, for example: end of life care is a right, how they want to manage decisions, people are there to advocate for them;
- Intermediate outcome – illuminating data on SF experience in the last 2 years of life, using claims data to see variations across SF to justify resources and preserve the work;
- Create a paradigm shift so that end of life taboo is removed – start "death ed" like "sex ed" earlier in the lifecycle;
- End of Life Week – 55% of participants were <45 yrs old

- Having an educated workforce and not burnt out – ie CNAs in nursing homes have huge turnover;
- Social supports are medically necessary – such as rides, shelter, food, payers are paying, etc.;

- Ensuring sustainable structure for caregivers;
- Supporting the 30% of older adults in SF who live alone;
- Looking at the American Health Care Paradox by Betsy Bradley, a public health professor at Yale;
- We need a mechanism for getting stories out to engage the community – Story Corps, media, etc.
- "Collude and plan" when media outlet comes out
- Engaging CFOs (unclear what acronym stands for) with their own stories

Group C:
- Community care services (team approach) or those ------------ dying at home;
- Opportunity to consider/express wishes for end of life care;;
- Advanced care planning
- Decreasing short LOS (unclear what acronym stands for) in hospice and support;
- Resource directory of available services;
- Increase community services as well as medical services, ---- end of life – cost impact;
- Aware/understanding of palliative care services;
- Culturally congruent manner and language access;
- Health care community (not palliative care community) – aware of/adopt palliative care;
- Good community partners – support for those require ----- services/support or don't have ---

WHAT DATA IS NEEDED TO ACHIEVE SUCCESS?
Group A:
Baseline metrics, such as:
- ------ denominator
- Hospice referral/length of stay improves;
- Based on payer data;
- What are the specific needs of: isolated, elder LGBT, ethnic/racial groups, frail/homebound, mentally ill, homeless, etc.;
- Patient's wishes are tracked over time and honored by all parties of the system;
- Quality of care in health care systems and post acute work;
- POLST registry

Group B:
- Recognition that some data will be stories, some will be numbers (quantitative and qualitative);
- Much of our target population is isolated, only meet them when they come to emergency department;
- Recognition that the data we need is from family caregivers;

- Getting doctors on board (or at least out of the way) – for example, saturate primary care physicians with education, telling them how to refer if they aren't good at it, etc. For example, average doctor only has 3-4 "dying patients" in their panel;
- "Do you know what palliative care means?" – what are the gaps, it's like a bazooka firing at multiple targets at the same time;
- Ask doctors what are the barriers?
- What is a BIG simple thing that you can do to make a change and leverage that?
- Workforce reflects the diversity of the population we are serving;
- Making sure the data reflects what the PATIENT wants (not just Medicare metrics, for example)

Group C:
- Number of hospital deaths;
- Number of palliative care consults;
- Number of POLST's;
- Surveys of persons who complete Advanced Care Planning;
- Medicare/MediCal data claims;
- Resource utilization number/directory;
- Community based organization data and other claims data;
- Survey levels of awareness;
- Measurements in non-English;
- Referral patterns.

Next Steps: Stupski team is pulling together a steering committee, which will include Joan Teno, Christine Ritchie, Shireen McSpadden, Anne Kinderman, Randy Morris and they are looking for one more member in Alameda County that is a palliative care clinician.

Next meeting date:
Friday, February 2nd, 2017, 2:00 – 3:30pm
1650 Mission Street, 5th floor, Golden Gate room